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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretariat

The Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Prepared pursuant to Council resolution 24/6, the report focuses on the right of adolescents to the enjoyment of the highest attainable standard of physical and mental health and on the imperative to implement measures necessary to guarantee optimum health and development in accordance with the unique nature of adolescence.

In the report, the Special Rapporteur elaborates on mental health, the rights to sexual and reproductive health, and substance use and drug control, in view of the particular challenges they pose in balancing adolescents' emerging autonomy with their right to protection.

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I. Introduction

1. Adolescence (10-19 years of age) is a life stage when inequities become more sharply differentiated in terms of access to services, life decisions and future trajectories. Foundations laid down during adolescence, in terms of emotional security, health, education, skills, resilience and the understanding of rights will have profound implications for the social, economic and political development of adolescents. The costs of failing adolescents are high, which is why a powerful case exists for paying greater attention to the right of adolescents to the highest attainable standard of health and development.

2. There is a growing focus on adolescence within the international health and development community, as reflected, most notably, in the *Global Strategy on Women's, Children's and Adolescents Health 2016-2030*. These are important and welcome commitments that now need to be translated into action on the ground.

3. The population of adolescents globally is estimated to be over 1.2 billion. 88 per cent of whom live in developing countries.[1] Adolescents represent 18 per cent of the world's population. Although adolescence is inherently characterized by relatively low mortality compared to other age groups, it is associated with emerging and complex risk factors, resulting in patterns of behaviour that affect long-term morbidity and mortality.[2] Likewise, adolescents are one of the groups that existing health services serve least well.[3]

4. It is estimated that 1.3 million adolescents died in 2012 from preventable or treatable causes.[4] Road traffic accidents, suicide and homicide, violence and war, drowning and fire-related incidents account for about 40 per cent of all deaths among youth (people aged between 15 and 24 years).[5] A small percentage of adolescents suffer from life-limiting and sometimes terminal illness, of which a majority are estimated to have no access to palliative care.[6]

5. Lack of access to safe reproductive health services and information contributes to adolescent girls among the most at risk of dying or suffering from serious or lifelong injuries associated with early pregnancies and childbirth. The lack of effective adolescent mental health policies and services leads to significant failures in emotional and social development, including violence against and among adolescents. Nearly all these risks are preventable, with outcomes grounded in physical and social environments and frequently mediated by their behaviours.

6. The rate and breadth of developmental change during adolescence is second only to that experienced in early childhood.[7] While investments during the past 20 years have resulted in enormous gains for children in the early years,[8] far less recognition has been

[1] United Nations, *World Population Prospects: The 2010 Revision* (2011).

[2] World Health Organization (WHO), *World Health Statistics 2014*.

[3] WHO, *Health for the World's Adolescents*. Available from http://apps.who.int/adolescent/second-decade/files/1612_MNCAH_HWA_Executive_Summary.pdf.

[4] WHO, "Adolescents: health risks and solutions", factsheet No. 345 (2014).

[5] George Patton and others, "Global patterns of mortality in young people: a systematic analysis of population health data", *The Lancet*, vol. 374 (2009), pp. 881-892.

[6] Stephen Connor and others, "Assessment of the need for palliative care for children in South Africa", *International Journal of Palliative Nursing*, vol. 20, No. 3 (March 2014), pp. 130-134; and WHO and the World Palliative Care Alliance, *Global Atlas of Palliative Care at End of Life* (2014), p. 19.

[7] R.M. Viner and others, "Adolescence and the social determinants of health", *The Lancet*, vol. 379, No. 9826 (April 2012), pp. 1641-1652.

[8] A/70/213.

afforded by policymakers to the implications of development in the second decade of life. Over the past 50 years, health has improved far less among adolescents than it has among young children.[9]

7. While there are many health issues of concern during adolescence, in the present report the Special Rapporteur focuses on mental health, substance use and drug control, and the rights to sexual and reproductive health, in view of the particular challenges they pose in balancing adolescents' emerging autonomy with their right to protection. Using the right-to-health framework, the Special Rapporteur underlines the importance of valuing adolescents' strengths and engaging with them as partners in informing and shaping the measures needed to realize the right to health and the optimum development of adolescents.

8. The Special Rapporteur recognizes the heterogeneity of adolescence and that definitions vary by country and region. However, to promote consistency and facilitate the measurement of adolescent health, this report adopts the definition of the World Health Organization, which views adolescents as persons between the ages of 10 and 19 years (until the twentieth birthday).[10]

II. Understanding adolescence and its implications for the right to health

A. A period of transition

9. Adolescence is a life stage of intrinsic value, not merely a transition between childhood and adulthood. It is a critical developmental stage characterized by growing cognitive abilities and emotional competencies, during which the brain has substantial neural plasticity.[11] The physical, mental and social potential established during the second decade contributes to enhanced intellectual ability and emotional functioning throughout adulthood.[12]

10. Adolescent health is the result of interactions between early childhood development and the specific biological and social role changes that accompany puberty, shaped by social determinants and by risk and protective factors that affect the uptake of health-related behaviours.[13] While adolescents themselves have the capacity to contribute to their own health and well-being, they can only achieve this goal if States respect and protect their rights and provide them with access to the necessary conditions, services and information.

11. Adolescence is a period of development towards increasing capacity for independent decision-making, moving away from the protective environments associated with earlier childhood. It is accompanied by greater experimentation, risk-taking and impulsivity and by the increased influence of the peer group. These behaviours contribute to building resilience, character and self-confidence and to the exploration and understanding of boundaries, and reflect the gradual adjustment from protection towards autonomy. Accordingly, while adolescents under 18 years of age continue to be entitled to protection from violence, abuse and exploitation, as well as to consideration of their best interests,

[9] Susan Sawyer and others, "Adolescence: a foundation for future health", *The Lancet*, vol. 379, No. 9826 (April 2012), pp. 1630-1640.

[10] See www.who.int/maternal_child_adolescent/topics/adolescence/en/ and www.who.int/maternal_child_adolescent/documents/fth_adh_98_18/en/.

[11] Susan Sawyer and others, "Adolescence: a foundation for future health".

[12] WHO, *Health for the World's Adolescents*.

[13] Susan Sawyer and others, "Adolescence: a foundation for future health" (abstract).

under the Convention on the Rights of the Child, the nature of those protections and their application must reflect the emerging competencies acquired throughout adolescence.

12. The transition towards adulthood is characterized by the changing nature of relationships. Across cultures, adolescents begin to attach far greater significance to and are increasingly influenced by their peer group and less by family and caregivers.[14] Adolescents also begin to explore their sexuality, sexual orientation and gender identity. There is considerable diversity in combinations of gender identities, expression and sexual orientation, irrespective of whether such diversity is culturally accepted.[15] It is increasingly clear that sexual orientation and gender identity derive from a complex interplay of biological, genetic and social factors and that individuals have little or no choice in its determination.[16]

13. Supporting adolescents to navigate successfully the challenging path towards healthy emotional, psychosocial, physical and sexual development requires recognition of their rights to information, freedom of expression and association, protection from all forms of violence, safety, bodily integrity and family life, and respect for their dignity and evolving capacities.

B. Challenges to the right to health for adolescents

14. Although opportunities for adolescents in many parts of the world have improved in recent years, the second decade of life is associated with exposure to increasing risks to the right to health, including violence, abuse, sexual or economic exploitation, trafficking, harmful traditional practices, migration, radicalization, recruitment into gangs or militias, self-harm, substance use and dependence and obesity. Gender inequalities become more significant as, for example, girls become exposed to child marriage, sexual violence and lower levels of enrolment in secondary education. The world in which adolescents live poses profound challenges, including poverty and inequality, climate change and environmental degradation, urbanization and migration, radical changes in employment potential, aging societies, rising health-care costs and escalating humanitarian and security crises.[17]

15. States policies towards adolescents are too often characterized by targeted or punitive interventions aimed at addressing problems such as juvenile delinquency and violence, as well as perceived challenges, including substance use and sexual activity; too little attention is typically paid to building positive environments in which adolescents can thrive. Punitive and excessively biomedical interventions ignore the powerful social and economic determinants influencing adolescent behaviour, opportunities and well-being. Stigmatizing, demonizing and discriminating against adolescents by, for example, criminalizing or pathologizing their behaviours and diversities, negatively affects their socially perceived roles, self-esteem, well-being and sense of empowerment. These approaches fail adolescents, their holistic development and their right to health.

16. One-size-fits-all policies designed for children or youth often fail to address adolescents, particularly 10-14 year-olds. Lack of awareness or understanding of their unique health needs can render adolescents invisible. Adolescents face multiple barriers to

[14] Clea McNeely and Krishna Bose, "Adolescent social and emotional development : a developmental science perspective on adolescent human rights", in *Human Rights and Adolescence*, Jacqueline Bhabha, ed. (2014).

[15] Ibid.

[16] See www.apa.org/topics/lgbt/orientation.aspx.

[17] UNICEF, *The State of the World's Children 2011: Adolescence — An Age of Opportunity* (2011).

health services, including the following: restrictive laws and policies; unavailability of contraception or safe abortions; inaccessible services owing to lack of information, distance or cost; failure to ensure privacy and confidentiality; parental consent or notification requirements; provision of services in a manner that is disrespectful, hostile, judgemental or lacking sympathy; and discrimination against particular groups of adolescents, including those with disabilities, those living and working on the streets or in the sex trade and those from historically marginalized groups.[18] States have positive human rights obligations to guarantee adolescents' rights and meaningfully engage with them in identifying their needs and priorities.

17. Rapid globalization and associated social and cultural changes, reinforced by the digital world, mean that many adolescents inhabit a world very different from that of the adults around them in relation to information, the speed of change, social norms, risks, aspirations and opportunities. While these rapidly changing environments offer important opportunities for adolescents, they can also pose significant challenges to their rights, for example to privacy, informed consent and freedom from exploitation, with significant implications, in particular for their mental health and well-being. Furthermore, the speed of change can inhibit intergenerational understanding, challenging the capacity of parents and other caregivers to provide the guidance necessary to protect and promote adolescents' right to health.

18. The lack of data disaggregated by age, sex and disability poses one of the biggest challenges to promoting adolescent rights.[19] Without adequate data, States lack evidence to inform health policy, identify gaps and support the allocation of appropriate resources.

C. Opportunities for realizing the right to health

19. Adolescents are actors for social change, and are able to bring dynamism, flexibility, creativity and energy towards the realization of their own and others' rights to health. States should adopt a human rights framework for adolescent health guided by the recognition of their strengths, capacities and contributions, while also addressing the impact of social determinants of health. Respecting and engaging with adolescents and treating them as a resource contributes to building foundations for emotional security, health, education and the skills needed for the full and effective realization of the right to health.

20. Adolescents have the right to play an increasingly important role in the determination of their own health care. Respect and recognition of their capacities is intrinsic to the enhancement of positive health outcomes. Forging partnerships with adolescents is the key to shaping an environment that enables the realization of their right to health.

21. In particular, adolescents' leading role in using and shaping new communications technologies places them in a position to build and utilize networks to promote their right to health, for example through information dissemination, data gathering, health campaign design, health education, peer-to-peer education and counselling and conflict mediation. A number of e-health and web-based interventions and mobile applications can provide information, increase access to care, engage adolescents in treatment and initiate aftercare. These skills and capacities mean that adolescents are uniquely positioned to contribute to the attainment of the Sustainable Development Goals, in particular Goal 3, as well as to

[18] WHO, *Making Health Services Adolescent Friendly* (2012).
[19] UNICEF, *The State of the World's Children 2011*.

monitoring and holding Governments to account on the commitments made (General Assembly resolution 70/1).

III. Right to health in adolescence

A. Understanding the right to health

22. The Convention on the Rights of the Child provides a comprehensive normative and legally binding framework to address the right to health of adolescents under the age of 18, while other treaties, such as the International Covenant on Economic, Social and Cultural Rights, provide a framework relevant for all adolescents, including those aged 18 and 19.

23. Further group-specific protections are found in other human rights treaties, but the Committee on the Rights of the Child has been at the forefront of efforts to apply the right to health in the context of adolescents, notably in its general comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child and general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health.

24. The right to health of adolescents is closely related to other human rights included in these treaties, such as the rights of the child to healthy development, education, play and recreation, social security and privacy, and to being free from torture, all forms of violence and economic, sexual and other forms of exploitation. The right to health is also inextricably linked to non-discrimination and equality, participation and accountability. Adolescent health and development need to be promoted in the context of a holistic and comprehensive approach to the wider determinants affecting the opportunities, choices and consequent development of adolescents.

25. The right to health provides a valuable normative framework grounded in a commitment to promote the best interests of adolescents while acknowledging their evolving capacities to take increasing levels of responsibility for their own health care. It also places a legal obligation on States to progressively realize the highest attainable standard of health of adolescents; eliminate discrimination and inequalities that obstruct equitable enjoyment of the right to health; ensure the participation of adolescents in relevant efforts; devote maximum available resources to the right to health of children; develop suitable laws and policies, including a comprehensive national health plan that addresses adolescents' right to health; and ensure accountability, including effective remedies.

26. The private sector is a significant provider of health care in many countries and plays a major role in the development and refinement of drugs and health-related products and technology. States should ensure that benefits accrue to all adolescents.[20]

B. Health care and other health-related services essential for adolescent health

27. States must ensure that health systems, including health-care services, in cooperation with other relevant services, such as social, child protection and education services, are responsive to the right to health of adolescents. They should address the full spectrum of adolescent health and development, including health promotion, sexual and reproductive

[20] Committee on the Rights of the Child general comment No. 15, para. 42.

health, mental health, palliative care, unintentional and intentional injuries, violence, and health-compromising behaviours that may begin during adolescence.

28. Rather than only setting up separate interventions and facilities for adolescents, efforts should be made to ensure that adolescents receive adequate attention in all policies, strategies and programmes that are relevant to them. Health systems should be designed and services should be delivered in a way that respects the right to health and other related rights of adolescents, in accordance with their evolving capacities. This can only be achieved by guaranteeing the right of adolescents to be heard and to contribute to the planning, implementation, monitoring and evaluation of services.

29. The right to health gives rise to an obligation of States to ensure the availability, accessibility, acceptability and quality of health services, goods and facilities. States must ensure that sufficient health facilities, goods, services and programmes are available to meet the needs of adolescents, especially the most marginalized.

30. Services, goods and facilities must be accessible to all adolescents without discrimination on any grounds. This includes access to information on their health, as well on the nature, availability, location, costs and timing of services. Services must be physically accessible, including to adolescents in remote or rural communities and adolescents with disabilities, and be located in spaces that provide adolescents with confidence that their specific health-care needs will be met.

31. Services and goods must be affordable, considering that adolescents rarely have financial means or autonomy, and accessible, directly and without parental support. In practice, it should be recalled that user fees can obstruct access to services.

32. States should develop a core package of interventions for adolescents, including to sexual and reproductive health services, that are available free of charge. Services must be designed and delivered in a manner consistent with the evolving capacities, developmental needs and the best interests of adolescents. They must respect adolescents' right to privacy and confidentiality, address different cultural needs and expectations and comply with ethical standards. Services must be sensitive to gender and lesbian, gay, bisexual, transgender and intersex status, they must be non-judgemental regarding adolescents' personal characteristics, lifestyle choices or life circumstances and they must treat all adolescents with dignity and respect, consistent with their status as rights holders.

33. All health-related services must be appropriate and of good quality, with skilled personnel who have been adequately trained, in particular on adolescents' right to health. Equipment and drugs must be appropriate for adolescents and regular assessments of the quality of health-care services undertaken.

34. The health sector should take the lead in development plans for adolescents' right to health. However, intersectoral collaboration is vital, including among the education and social protection sectors, and right-to-health considerations must be integrated into relevant policies and strategies.

C. Underlying and social determinants of health

35. The right to health is not only a right to health care, but a right to underlying and social determinants of health. Social determinants are the conditions in which people are born, grow, live, work and age that influence their health. The evidence overwhelmingly shows that the strongest determinants of adolescent health worldwide are structural factors

such as national wealth, income inequality, gender systems and access to education.[21] Additional determinants include social norms, laws and policies and the physical environment, as well as the online social media environment, which plays an increasingly influential role in adolescents' lives.

36. States must take legal, policy and other measures to address the underlying and social determinants of adolescent health, including: road and environmental safety; racial prejudice; access to education; persistence of forced and early marriage; corporal punishment; social, economic, political, cultural and legal barriers to health services, including sexual and reproductive health services; inadequate social protection; institutionalization; punitive drug laws; absence of comprehensive sexuality education; criminalization of exposure, non-disclosure of HIV status and transmission of HIV; criminalization of same-sex relationships; and lax legal frameworks governing the sale of tobacco, alcohol and fast foods.

37. Measures to address the right to health should be holistic and integrated, go beyond the provision of health services and be underpinned by cross-departmental commitment. States should take account of and respond to the particular challenges faced by different groups, such as younger and older adolescents, males, females and lesbian, gay, bisexual, transgender and intersex persons.

Right to protection from all forms of violence

38. Exposure to violence increases during adolescence, to the point that it is a primary cause of mortality and morbidity in the second decade.[22] Violence occurs in the family, in the community, at work or at the hands of State actors.

39. Adolescent girls, adolescents with disabilities, lesbian, gay, bisexual, transgender and intersex adolescents, adolescents living in institutions and adolescents from communities with a proliferation of unregulated weapons or experiencing armed conflict are among those particularly vulnerable to violence. The risks for girls include, for example, exposure to sexual violence and exploitation, forced and early marriage, honour killings and abusive practices often carried out in health-care settings, such as forced sterilization and forced abortion for girls with disabilities, and forced virginity testing.[23]

40. Violence in intimate relationships among adolescents is also common, resulting in both immediate and potential long-term consequences for their physical, mental and social health. In addition to its immediate health consequences, the trauma of violence perpetrated by an intimate partner can lead to long-term physical injuries, to both immediate and delayed-onset health problems and to experiences of repeated revictimization.[24]

41. Lesbian, bisexual and transgender youth are at risk of "punitive" rape on the basis of their sexual orientation or gender identity. Adolescents suffer disproportionately from the effects of gun violence and significant numbers of adolescents face serious harm or death as a consequence of armed conflict.

42. The focus in the Sustainable Development Goals on tackling violence against women and girls is welcome. However, significant levels of violence are also experienced

[21] R.M. Viner and others, "Adolescence and the social determinants of health".

[22] WHO, *Health for the World's Adolescents*.

[23] See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices.

[24] C.C. Pallitto and V. Murillo, "Childhood abuse as a risk factor for adolescent pregnancy in El Salvador", *Journal of Adolescent Health*, vol. 42, No. 6 (2008), pp. 580-586.

by adolescent boys. Boys caught up in violent crime are often exposed to harsh punitive responses by States that create a downward spiral of increasing violence with profound detriment to their physical and mental health and well-being.

43. In line with the Convention on the Rights of the Child and the recommendations of the Committee on the Rights of the Child, States must introduce measures addressing the specific forms of violence faced by adolescents.[25] Recognizing the right of adolescents to exercise increasing levels of responsibility should not obviate States' obligations to guarantee them protection.

44. Rights to protection and increasing participation are mutually reinforcing. Guaranteeing adolescents the right to be heard, to challenge rights violations and to seek redress empowers them to exercise agency in their own protection.[26] Failure to do so will condemn millions globally to continuing and extreme violations of their rights.

45. The right to protection extends to violence in the digital environment. With growing use of social media and online activity, adolescents are increasingly vulnerable to cyberbullying, which is associated with a wide range of mental, psychosocial, cognitive, educational and health problems, including depression and suicide, as well as other poor coping responses such as problems with alcohol and other drug use. However, it is neither appropriate nor possible to seek to restrict adolescents' access to the digital environment. Therefore, States should fulfil their obligations through the adoption of holistic strategies aimed at enhancing adolescents' capacities to protect themselves from online harm, strengthening legislation and law enforcement mechanisms to tackle online abuse, including cross-border abuse, combating impunity and training parents and professionals who work with children.

Family life

46. The family, in its diverse forms and arrangements, refers to the essential environment for the well-being, protection and development of children and adolescents. The recognition of diverse family forms is necessary to ensure the protection and promotion of the rights of all of children and adolescents, without discrimination of any sort.

47. Safe and supportive families are crucial to helping adolescents develop to their full potential and attain the best health into adulthood. Therefore, support of the family environment is very important for the physical and mental health of children and adolescents. States should develop policies and services that support families and strengthen their parenting competencies so that all children can grow in healthy family environments.

48. Policies designed to protect families and family values should avoid measures that undermine the human rights of individual family members, including women, adolescents and younger children.[27] Such approaches can be detrimental as they may, in the name of traditional values, tolerate or condone violence, reinforce unequal power relations within family settings and, therefore, deprive adolescents from the opportunity to exercise their basic rights.

49. States should take specific measures to ensure that adolescents with disabilities enjoy their right to family life and are not removed from their families against their will.

[25] See articles 19, 37 and 39 of the Convention on the Rights of the Child and Committee on the Rights of the Child general comment No. 13 (2011) on the right of the child to freedom from all forms of violence.

[26] Committee on the Rights of the Child general comment No. 13, para. 63.

[27] See A/HRC/31/37, para. 23.

States should ensure that information, training and support are provided to parents to enable them to help their adolescent children attain the highest attainable standard of health.

D. Right to non-discrimination

50. The right to non-discrimination is fundamental to realizing adolescents' right to health. Discrimination encompasses any distinction, exclusion or restriction that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.[28]

51. Adolescence itself can be a basis for discrimination, with many adolescents treated as dangerous or hostile, incompetent to make decisions, incarcerated, exploited or exposed to violence as a direct consequence of their age. Health-care providers may perpetuate discrimination against adolescents when they deny them health services or contraceptive supplies or treat them poorly, which can make adolescents reluctant to seek the health-care they need. Adolescents belonging to marginalized groups or sectors, such as girls, racial or ethnic minorities, indigenous populations, lesbian, gay, bisexual, transgender and intersex adolescents, refugees and adolescents with disabilities, face a heightened risk of exclusion.

52. To achieve substantive equality, States must take special measures in order to diminish or eliminate conditions that cause discrimination"[29] by introducing comprehensive legislation and policies, as well as affirmative action measures, to diminish or eliminate structural barriers and historic conditions that result in direct or indirect discrimination against any group of adolescents on any grounds.

E. Participation

53. International human rights standards require the free, active and meaningful participation of people in decisions that affect their lives.[30] In particular, States' obligations under article 12 of the International Covenant on Economic, Social and Cultural Rights require that the right of individuals and groups to participate in decision-making processes affecting their health and development must be an integral component of any relevant policy, programme or strategy.

Right of adolescents to be heard and regarded as the subjects of rights

54. Children, including adolescents, lack the full autonomy of adults while being subjects of rights. Article 12 of the Convention on the Rights of the Child addresses the legal and social status of children, recognizing their capacity to form their own views and to express them freely in all matters affecting them and giving them due weight in accordance with age and maturity.[31]

55. This has been broadly conceptualized as the right to and principle of participation, and is central to the realization of adolescents' right to health, both in individual matters relating to their own health care and in wider issues such as the design and development of

[28] See Human Rights Committee general comment No. 18 (1994) on non-discrimination.

[29] See Committee on the Rights of the Child general comments No. 15, para. 12, and No. 5 (2003) on general measures of implementation of the Convention on the Rights of the Child, para. 12.

[30] Universal Declaration of Human Rights, art. 21, and the International Covenant on Civil and Political Rights, art. 25.

[31] See Committee on the Rights of the Child general comment No. 12 (2009) on the right of the child to be heard.

health-related services. It implies a fundamental shift in the traditional status of the child as a passive recipient of adult decisions and interventions.

36. In order to ensure the relevance and efficacy of interventions, adolescents' experiences, concerns, knowledge and creativity should be utilized in the development, implementation and monitoring of relevant legislation, policies, services and programmes affecting their right to health and development at the school, community, local and national levels.[32] Consultative mechanisms alone are insufficient to fulfil the right to be heard and to be taken seriously. Adolescents must be afforded safe spaces with opportunities to identify for themselves issues of most concern to them and to enable them to act on those concerns. Particular attention should be paid to adolescents with disabilities, who must be provided with disability and age-appropriate assistance to realize this right.[33]

Right to respect evolving capacities

57. During adolescence, the right to be heard and to be taken seriously transitions into the right to make autonomous decisions about one's health care and treatment. The concept of children's evolving capacities is an enabling principle addressing the process of maturation and learning through which children progressively acquire competencies and understanding.[34]

58. Not only is adolescence a period of considerably enhanced cognitive development, it is also associated with greater self- and social awareness, and the ability to grapple with complexity and to take into consideration the perspectives of others.[35] These developments have profound implications for adolescents' capacities to take increasing levels of responsibility for decision-making in respect of the right to health.

59. However, all too often States continue to deny adolescents the right to make autonomous and confidential decisions with regard to accessing health services by requiring parental notification or consent. These restrictions often make adolescents reluctant to access needed services so as to avoid seeking parental consent, which may result in rejection, stigmatization, hostility or even violence.

60. States are urged to consider the introduction of a legal presumption of competence that an adolescent seeking preventive or time-sensitive health goods and services, including for sexual and reproductive health, has the requisite capacity to access such goods and services. Where minimum ages of consent exist, as the Committee on the Rights of the Child has argued, any adolescent below that age and able to demonstrate sufficient understanding should be entitled to give or refuse consent. At a minimum, States should ensure a minimum age well below 18 years at which adolescents have the right to consent to or refuse services without mandatory authorization or notification of parent, guardian, spouse or intimate partner. The right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit.[36]

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[32] Ibid.

[33] Convention on the Rights of Persons with Disabilities, art. 7 (3).

[34] See Convention on the Rights of the Child, art.5, and Committee on the Rights of the Child general comment No. 7 (2006) on implementing child rights in early childhood.

[35] Sarah-Jayne Blakemore and S. Choudhury, "Development of the adolescent brain: implications for executive function and social cognition", *Journal of Child Psychology and Psychiatry*, vol. 47, Nos. 3-4 (2006), pp. 296-312; and Sarah-Jayne Blakemore and Katheryn L. Mills, "Is adolescence a sensitive period for sociocultural processing?", *Annual Review of Psychology*, vol. 65 (2014), pp. 187-207.

[36] Committee on the Rights of the Child general comment No. 12.

61. Particular regard must be afforded to the barriers faced by adolescents with disabilities, as their views should be given due weight in accordance with age and maturity on an equal basis with others and as they must be provided with opportunities for supported decision-making.[37]

F. Accountability

62. Accountability, including its constituent components monitoring, review and redress, is essential if the right to health is to be more than an aspiration.[38] Accountability reveals where progress has been made and where it has not been made, allows duty bearers to explain what they have done and make adjustments, and provides an opportunity for rights holders, including adolescents, to engage with duty bearers in the promotion and protection of their rights and to seek redress where violations have occurred.[39]

63. The commitment expressed in the *Global Strategy on Women's, Children's and Adolescents' Health 2016-2030* to improve national and global accountability, including for adolescent health, is welcome, as is the broader commitment to accountability in the Sustainable Development Goals. In this connection, States should ensure the quality and timely collection of appropriately disaggregated data and that laws, policies and programmes concerning adolescent health are transparently and regularly reviewed. National assessments or public inquiries into adolescents' right to health are welcome and could be conducted by national institutions.

64. Adolescents, together with other key civil society stakeholders, should play an active role in accountability. They should be actively involved in the determination of indicators at the national and local levels that reflect the issues they consider to be of critical importance in realizing the right to health.

65. To achieve this, all relevant policies should be devised, and periodically reviewed, on the basis of a transparent process and with the participation of adolescents, and should include right to health indicators and benchmarks.[40] Indicators should be disaggregated on suitable grounds, including those identified in the Sustainable Development Goals, namely age, income, gender, race, ethnicity, migratory status, disability and geographic location, in order to monitor the health status of marginalized groups and sectors of adolescents (see target 17.18). Adolescents and other relevant civil society actors should also be actively involved in review processes.

66. States should ensure adolescents have access to effective remedies to adjudicate violations of their right to health, through the provision of supportive, child-friendly redress mechanisms with the authority to adjudicate claims made by adolescents and filed on their behalf, as well as access to subsidized or free legal services and other appropriate assistance (see A/HRC/25/35). Furthermore, States should put in place preventive remedies where adolescents can challenge denials of access to health services.[41]

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[37] Committee on the Rights of Persons with Disabilities general comment No. 1 (2014) on equal recognition before the law.

[38] WHO Commission on Information and Accountability, *Keeping Promises: Measuring Results* (2011).

[39] Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (2008).

[40] Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 43 (f).

[41] See *LC v. Peru*; *P&S v. Poland*.

IV. Promotion of emotional well-being and mental health

A. Nature and prevalence of mental health problems in adolescence

67. Globally, it is estimated that approximately 20 per cent of 14-24 year olds experience a mental health condition each year.[42] The transition from childhood to adulthood is a period of heightened vulnerability (half of all lifetime mental disorders appear by the age of 14 years) caused to a significant extent by the physical, psychological and emotional changes arising during this period. Research indicates that depression is the primary cause of illness and disability among adolescents and suicide is the third leading cause of death.[43]

68. Poor mental health can affect the health and development of adolescents more generally and is associated with many damaging health and social outcomes, such as substance use, the inability to form relationships, dropping out of school or academic underperformance and delinquent behaviours, together with increased likelihood of poverty and poorer employment opportunities.[44]

69. The risk of experiencing mental ill-health is heightened by poverty and by adverse childhood events, including, for example, sexual and emotional abuse, bullying and parental loss. Adolescents in post-conflict or disaster settings or who are homeless and street-involved, orphaned, lesbian, gay, bisexual, transgender and intersex or involved with the juvenile justice system are also at greater risk. Adolescents in the juvenile justice system suffer substantially higher rates of mental health conditions than those in the general population, with an estimated 70 per cent having at least one diagnosable mental health condition.[45]

70. The international human rights framework establishes the clear duty of States to promote adolescents' mental health and emotional well-being, provide appropriate mental health treatment and care and ensure that mental health laws fully recognize the rights of those with mental illness.[46] Target 3.4 of the Sustainable Development Goals is to reduce by one third premature mortality from non-communicable diseases through prevention, treatment and the promotion of mental health and well-being. That target must be applied fully to adolescents.

71. Despite these obligations and commitments, there is a worrying lack of recognition or awareness of the nature and scale of mental health problems among adolescents in many countries. Evidence indicates that many adolescents consider emotional well-being to be the most important health problem they face and would like more access to quality mental health care.[47]

72. The nature of adolescents' mental health needs differs from that of adults and requires targeted services. However, a national health system of well-functioning, effective

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[42] Vikram Patel, Benedetto Saraceno and Arthur Kleinman, "Beyond evidence: the moral case for international mental health", *American Journal of Psychiatry*, vol. 163, No. 8 (2006), pp. 1312-1315; and UNICEF, *The State of the World's Children 2012: Children in an Urban World* (2012).

[43] WHO, "Adolescents: health risks and solutions", factsheet No. 345.

[44] United Nations, *Mental Health Matters: Social Inclusion of Youth with Mental Health Conditions*, (2014).

[45] Ibid.

[46] Convention on the Rights of the Child , arts. 24 (1) and (2) (b) and 6; Committee on Economic, Social and Cultural Rights general comment No. 14; and E/1995/22-E/C.12/1994/20.

[47] WHO, *Health for the World's Adolescents*.

and adolescent-friendly services remains the exception rather than the rule. Less than one third of low- and middle-income countries have a designated youth mental health entity and most lack youth-focused mental health policies.[48] Where they do exist, they often fail to meet quality standards and may even be harmful to the health and development of adolescents. Adolescents may be detained for a long time in overcrowded, in-patient facilities where little attempt is made at rehabilitation or social integration.[49] These approaches violate adolescents' human rights and worsen, rather than ameliorate, mental health conditions.

73. Public and self-stigmatizing attitudes towards mental illness, concerns about confidentiality and lack of general understanding all serve as barriers to getting help, particularly among adolescents, a problem compounded by the lack of quality mental health services in low- and middle-income countries.[50] For adolescents, the attitude of service providers is more important than their technical expertise. Adolescents who seek services often experience negative or hostile responses from health-care providers, leading to a further reluctance to access help. Same-sex attraction is still considered by doctors in many countries to be a mental disorder.[51] Lesbian, gay and bisexual adolescents may be subjected to harmful therapeutic interventions intended to eliminate or suppress their sexual instincts. Such therapies have been deemed unethical, unscientific, ineffective and, in some instances, tantamount to torture.[52]

B. Promoting effective mental health services

74. Prevention of mental health problems and promotion of mental well-being in adolescence should be a central part of national health policies. Action plans should include programmes for evidence-based interventions that are well-funded and monitored and that aim to reinforce protective factors within adolescents, their families and communities.

75. Accordingly, the focus should be on building resilience, supporting parents, stimulating adequate help-seeking behaviours, creating positive peer groups and school environments, ensuring opportunities for influence and decision-making, increasing empowerment and emotional literacy. Furthermore, such programmes can also address risk behaviours such as bullying, suicidal behaviour, domestic violence and substance use.

76. Models based on over-medicalization and institutionalization should be abandoned and replaced with early interventions and comprehensive community-based multisectoral responses. Adolescent health policies must be developed with the involvement of professionals in the health, education and social welfare sectors, who can provide a flexible network of services, including schools, community outpatient and day care mental health services rooted in the evidence-based biopsychosocial model.[53]

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[48] United Nations, *Mental Health Matters*.

[49] Vikram Patel and others, "Mental health of young people: a global public-health challenge", *The Lancet*, vol. 369, No. 9569 (2007), pp. 1302-13.

[50] Amelia Gulliver, Kathleen Griffiths and Helen Christensen, "Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review", *BMC psychiatry*, vol. 10, No. 1 (2010), p. 113.

[51] United Nations Development Programme and USAID, "Being LGBT in Asia: China country report" and "Being LGBT in Asia: Cambodia country report".

[52] A/HRC/29/23.

[53] G. Thornicroft and M. Tansella, "The balanced care model for global mental health", *Psychological Medicine*, vol. 43, No. 4 (2013), pp. 849-863.

77. Cost-effective public health and psychosocial interventions, including social protection, psychoeducation, coaching, counselling and psychotherapy, as well as parent training, should be available and accessible to all adolescents in need and their families. Such approaches aim at improving behaviour, holistic development and specific life skills, and reduce the need for medication.[54] Medications and inpatient services may be needed as part of treatment plans in complex cases of mental conditions, but these treatment modalities should be used with caution. Schools are well-placed to promote emotional well-being and mental health and to prevent mental health problems, for example, through classes on mental health literacy.[55]

78. Psychosocial interventions are not a luxury: on the contrary, when used in a manner consistent with adolescents' rights, ethically and on the basis of evidence, they are essential interventions. Indeed, the World Health Assembly, in its resolution 65.4, has noted the increasing evidence of effectiveness and cost-effectiveness of such approaches to promote mental health and prevent mental disorders particularly among adolescents. Furthermore, the Committee on the Rights of the Child has strongly encouraged States to adopt and scale up these interventions, in line with their obligations to promote adolescents' right to health.[56]

79. States should invest in programmes to challenge outdated beliefs and negative attitudes about mental conditions through the dissemination of information. Adolescents of different ages and representing different perspectives should be consulted in the design, development, implementation and monitoring of mental health services. Investments must be made to address gender discrimination in mental health and to reach out to marginalized communities, which are disproportionately vulnerable to mental health problems and experience greater barriers in accessing services.

80. The right to mental health must be underpinned by legal frameworks that are fully compliant with human rights standards, which demand respect for the evolving capacities of adolescents with disabilities and their physical integrity. Adolescents with disabilities are vulnerable to neglect, mental and physical abuse, sexual violence and forced sterilization or contraception while detained in mental health care settings.

81. Accordingly, all institutions should adopt and publish principles and standards of care and establish safe and effective reporting mechanisms and systems for redress in line with international standards.[57] Monitoring mechanisms should be in place to ensure that violations of the rights of adolescents in mental health care settings can be reported and redress sought.

82. The vulnerability of the growing number of adolescents in refugee camps or seeking asylum is worrying. States are reminded of their broad international obligations to protect refugees[58] and ensure necessary assistance in the enjoyment of their rights, including the right to optimum mental health and well-being.

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[54] Peter Fonagy and others, *What Works for Whom?: A Critical Review of Treatments for Children and Adolescents* (2014).

[55] "A preparatory action related to the creation of an EU network of experts in the field of adapted care for adolescents with mental health problems: final report" (2015).

[56] Committee on the Rights of the Child general comment No. 15.

[57] See www.unicef.org/protection/alternative_care_Guidelines-English.pdf.

[58] Convention on the Rights of the Child, art. 22.

V. Adolescents' rights to sexual and reproductive health

A. Nature of and challenges associated with sexual and reproductive health rights

83. Healthy sexual development requires not only physical maturation, but an understanding of healthy sexual behaviours and a positive sense of sexual well-being. Sexual initiation can be a natural and healthy aspect of adolescence, and adolescents have the right to be provided with the tools and information to navigate sex safely. Sexual activity among adolescents is widespread, although rates vary significantly. Yet, adolescents around the world face significant discrimination and barriers in accessing the information, services and goods needed to protect their sexual and reproductive health, resulting in violations of their right to health.

84. Many adolescents, in particular girls and those identifying as lesbian, gay, bisexual and transgender, are deterred from approaching health professionals in anticipation of a judgemental attitude that results from social norms or laws that stigmatize or criminalize their sexual behaviour. Rights to sexual and reproductive health for many adolescents are further compromised by violence, including sexual and institutional violence, coercion into unwanted sex or marriage, and patriarchal and heteronormative practices and values. This reinforces harmful gender stereotypes and unequal power relations that make it difficult for many adolescent girls to refuse sex or insist on safe and responsible sex practices.

85. The vulnerability of boys to physical and sexual abuse and exploitation should be highlighted, together with the significant barriers they face in accessing sexual and reproductive information and services. Intersex adolescents often experience particular challenges because of irreversible and non-consensual surgeries performed during their early childhood and because of the natural development of their bodies.[59] Discrimination within the family and society, as well as discriminatory attitudes by health providers, can result in the denial of access to health services, while lack of knowledge and awareness within the medical profession further impedes access to quality care.[60]

86. Adolescents with disabilities are frequently subjected to forced medical treatment, including sterilization, abortion and contraception, which can constitute torture or cruel, inhuman or degrading treatment.[61] Girls with disabilities in particular experience alarmingly disproportionate levels of physical and sexual violence, frequently without any means of redress or access to justice.[62] Many health-care providers hold inaccurate, stereotypical views about individuals with disabilities, including assumptions that they are asexual, which serves to deny them access to sexual and reproductive health information, services and goods, as well as comprehensive sexuality education.[63]

87. AIDS is the second most common cause of death among adolescents globally.[64] Worldwide, adolescents in key population groups, including gay and bisexual boys, transgender adolescents, adolescents who exchange sex for money, goods or favours and adolescents who inject drugs, are also at a higher risk of HIV infection. Adolescent girls in

[59] A/70/213.
[60] A/HRC/32/44.
[61] A/HRC/22/53.
[62] A/66/230.
[63] Handicap International and Save the Children, *Out from the Shadows: Sexual Violence against Children with Disabilities* (2011), p. 13.
[64] WHO, *Health for the World's Adolescents*.

high-HIV burden countries are particularly vulnerable, making up 75 per cent of new infections in Africa in 2013,[65] with gender inequality, harmful traditional practices and punitive age of consent laws identified as drivers of the epidemic.[66] These sectors and groups face a disproportionately high risk of experiencing stigma, discrimination, violence, rejection by families, criminalization and other human rights violations when seeking sexual and reproductive health services, including denial of access to health-care services, such as HIV testing, counselling and treatment.

88. Rights to sexual and reproductive health are therefore of critical importance. Sexual health is defined as a "state of physical, emotional, mental and social well-being related to sexuality, not merely the absence of disease, dysfunction or infirmity".[67] Article 24 (2) (f) of the Convention on the Rights of the Child and article 12 (2) of the Convention on the Elimination of All Forms of Discrimination against Women both recognize the right to the provision of family planning education and services, including to adolescents, without discrimination on any grounds.[68] However, United Nations treaty bodies consistently raise concerns relating to the provision of sexual and reproductive health information, services and goods. They have also strongly affirmed that adolescents' sexual and reproductive health implicates a broad range of human rights, including to non-discrimination, freedom from torture or ill-treatment, privacy and education.[69]

B. Providing effective sexual and reproductive health services for adolescents

89. Given the scale of these concerns, target 3.7 of the Sustainable Development Goals, on ensuring universal access to sexual and reproductive health-care services, is welcome. To achieve this target, States will have to adopt a comprehensive gender-sensitive and non-discriminatory sexual and reproductive health policy for all adolescents and to integrate it into national strategies and programmes.[70]

90. These policies must be consistent with the human rights standards and recognize that unequal access by adolescents constitutes discrimination.[71] All adolescents must be guaranteed access to confidential, adolescent-responsive and non-discriminatory sexual and reproductive health information, services and goods, including family planning, modern forms of contraception, counselling, pre-conception care, maternal care, sexually transmitted infections, diagnosis and treatment, and safe abortion.[72] Adolescent sexual and reproductive health services must be welcoming, adolescent-friendly, non-judgemental and guarantee privacy and confidentiality. Health providers should also consider the establishment of dedicated clinic times and alternative locations for adolescents, particularly with regard to sexual and reproductive health services.

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[65] UNAIDS and the African Union, *Empower Young Women and Adolescent Girls: Fast-Tracking the End of the AIDS Epidemic in Africa* (2015).

[66] E/CN.4/2005/72.

[67] Paul Hunt and Judith Bueno de Mesquita, *The Rights to Sexual and Reproductive Health* (2006).

[68] Committee on the Rights of the Child general comment No. 15.

[69] *K.L. v. Peru*, CCPR/C/DJI/CO/1 and CAT/C/PER/CO/4.

[70] WHO, *Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations* (2014).

[71] Committee on Economic, Social and Cultural Rights general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights.

[72] Committee on the Rights of the Child general comments No. 4 and No. 15.

91. Furthermore, States should introduce measures to raise adolescents' awareness of their rights to sexual and reproductive health and to services and goods at the family, school and community levels. Age-appropriate, comprehensive and inclusive sexuality education, based on scientific evidence and human rights, should be part of the mandatory school curriculum, with special attention given to relationships, sexuality, gender equality and identity and sex characteristics, including non-conforming gender identities, responsible parenthood and sexual behaviour, and preventing early pregnancy and sexually transmitted infections.[73]

92. States are strongly encouraged to decriminalize abortion, in accordance with international human rights norms, and adopt measures to ensure access to legal and safe abortion services. Criminal laws with respect to abortion result in a high number of deaths, poor mental and physical health outcomes, infringement of dignity and amount to violations of the obligations of States to guarantee the right to health of adolescent girls.[74] Furthermore, information about and access to abortion services must be available, accessible and of good quality, without discrimination, at a minimum in the following circumstances: when the life or health of the mother is at risk, when the mother is the victim of rape or incest and if there is severe and fatal foetal impairment. Post-abortion care must be available and accessible to all adolescent girls irrespective of the legal status of abortion.

93. Prevention, care, treatment and support are mutually reinforcing elements in providing a comprehensive and effective response to HIV/AIDS.[75] All adolescents should have access to HIV testing and counselling, and evidence-based HIV prevention and treatment programmes. Health services should offer HIV-related information, testing, sexual and reproductive health services, contraception, condoms and HIV-related care and treatment, including antiretroviral and other medicines, diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections and other conditions, good nutrition and social, spiritual and psychological support, as well as family, community and home-based care.

94. The Special Rapporteur deplores the imposition of treatments to try to change sexual orientation and gender identity, including forced sex assignment surgeries for intersex youth, forced sterilizations and abortions for girls with disabilities, the use of surgery and hormone therapy to stunt the growth of children with developmental disabilities and remove their reproductive organs, and the pathologizing of transgender identity and same-sex attraction as psychiatric disorders. States should eliminate such practices and to repeal all laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation or gender identity and expression.[76] There is a need to reform and update national health information systems to include human rights concepts and variables such as lesbian, gay, bisexual and intersex status.[77]

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[73] General Assembly resolution 70/137 and UNESCO, *International Technical Guidance on Sexuality Education* (2009).

[74] A/66/254 and A/HRC/32/44.

[75] Committee on the Rights of the Child general comment No. 3 (2003) on HIV/AIDS and the rights of the child.

[76] See A/HRC/22/53; CRC/C/RUS/CO/4-5; CRC/C/GAM/CO/2-3, paras. 29-30; and CRC/C/CHE/CO/2-4, paras. 42-43.

[77] Pan American Health Organization resolutions CD50.R8 and CD52.R6.

VI. Adolescents, substance use and drug control

A. Nature of and problems associated with substance use in adolescence

95. Adolescence is a period of risk-taking and experimentation with greater likelihood of initiation into substance use. Adolescents are at higher risk of drug-related health harms, while substance use initiated in adolescence can more often lead to dependence than during adulthood. The most commonly used substances are alcohol, tobacco and solvents. Illicit drug use, in particular cannabis, is also common and in recent years unregulated novel psychoactive substances have become an important concern.[78]

96. Outside of high-income countries, data relating to adolescent substance use and related health harms are poor. Important differences exist among and within countries, between adolescents and their older counterparts and among groups of adolescents. For example, heavy episodic or binge use, especally of alcohol, is more common among young people.[79] Adolescents' access to services is limited in comparison to adults, for example, being under the legal age of majority can block adolescents from accessing certain services. Those identified at greatest risk of drug-related harms are those who are street-involved, excluded from school, have histories of trauma, family breakdown or abuse, and those living in families coping with drug dependence. Adolescent girls are at a higher risk of certain kinds of harm than boys, including HIV infection due to both sexual transmission and unsafe injecting practices. These factors demand concerted efforts to gather appropriately disaggregated data to better understand patterns of vulnerability so that services can be targeted and properly budgeted.

97. In addition to substance use, there are significant physical and mental health consequences to adolescents' involvement in the production of and trade in substances. Adolescents are involved at all stages of the licit and illicit drug supply chains. With regard to illicit drugs, in addition to sometimes hazardous work, adolescents can be exposed to organized crime, violence and counter-narcotics operations. More research is needed into the adolescent health implications linked to the production of drugs and the violence associated with the criminal market.

98. The harms associated with drug use and involvement in the drug trade cannot be disentangled from State responses. Evidence shows that repressive and punitive responses to drugs have not been effective in reducing drug use or supply[80] and that they have produced negative consequences, including violence and corruption.[81] Criminalization of drug use and personal possession, as well as drug user registries and police violence, drive young people from services, producing a health-deterrent effect. Prevention and education programmes that focus on zero tolerance create an environment where adolescents may be less likely to seek information about harms related to use. Adolescents have lost parents to drug-related violence and to prolonged incarceration for non-violent offences, with significant implications for their mental health.

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[78] UNODC, *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6).

[79] WHO, *Global Status Report on Alcohol and Health 2014*.

[80] Louisa Degenhart and others, "Toward a global view of alcohol, tobacco, cannabis and cocaine use: findings from the WHO World Mental Health Surveys", *PLOS Medicine*, vol. 5, No. 7 (2008); and European Commission, Netherlands Institute of Mental Health and Addiction and Rand Europe, *A Report on Global Illicit Drugs Markets 1998-2007* (2009).

[81] E/CN.7/2008/CRP.17.

B. Providing appropriate services to address adolescent substance use

99. States should adopt appropriate measures to protect children from illicit drug use and involvement in the illicit drug trade.[82] However, this must be read in the context of the protections afforded by the Convention on the Rights of the Child and other human rights obligations.[83] Almost all States have obligations under the three United Nations drug control conventions, which must be read in conformity with concurrent human rights obligations.[84] The Framework Convention on Tobacco Control contains specific provisions aimed at the protection of children and young people, and which complement the right to health.

100. States should provide prevention, harm reduction and dependence treatment services, without discrimination, and allocate a budget sufficient to the progressive realization of the right to health. These are not competing or alternative strategies but required components of a comprehensive approach to enable adolescents to seek the health services and information they are entitled to receive. All such services should comply with the availability, accessibility, acceptability and quality framework.

101. With regard to the prevention of substance use, children and young people should be provided with accurate and objective information,[85] which should be available in easy-to-understand formats or Braille. Scare tactics and misinformation are known to be ineffective, whereas building resilience and trust while focusing on those demonstrating risk-taking behaviours has delivered promising results. The United Nations Office on Drugs and Crime (UNODC) has produced guidance on drug prevention standards[86] to be used when designing prevention policies and porgrammes.

102. Prevention cannot justify disproportionate infringements of adolescents' rights, including their rights to privacy, bodily integrity and education. States are encouraged to continue to restrict and, when necessary, ban alcohol and tobacco advertising, which has too often targeted young people.

103. Substance dependence treatment must be tailored to the specific needs of adolescents. Adolescents must not lose their participation rights in any circumstance, including because of their substance use or dependence. Adolescents have the right to be heard when expressing opinions on their own health care and to give consent to treatment in accordance with their evolving capacities.[87] Confidential counselling and information must be available without parental consent. All drug detention centres where adolescents are arbitrarily detained and suffer extreme abuses must be closed.

104. There is an alarming lack of HIV-related harm reduction services designed for adolescents who inject drugs, as well as multiple barriers to accessing such services, including age restrictions in law, and absence of data on injecting drug use among children and young people in most countries.[88] Technical guidelines on HIV prevention, treatment

[82] Convention on the Rights of the Child, art. 33.

[83] Damon Barrett and John Tobin, "Article 33: protection of children from narcotic drugs and psychotropic substances", in *A Commentary to the United Nations Convention on the Rights of the Child*, John Tobin and Philip Alston, eds. (Oxford University Press, forthcoming).

[84] See A/65/255, para. 13.

[85] See CRC/C/GUY/CO/2-4, para. 50 (d); CRC/C/ALB/CO/2-4, para. 64 (b); CRC/C/ROM/CO/4, para. 71; CRC/C/SWE/CO/4, para. 49 (a); and CRC/C/BGR/CO/2, para. 50.

[86] https://www.unodc.org/unodc/en/prevention/prevention-standards.html.

[87] Committee on the Rights of the Child general comment No. 15.

[88] Harm Reduction International, *Global State of Harm Reduction 2012* (2012), p. 140.

care and support for young people who inject drugs have been developed,[89] and should form the basis of States' efforts in this regard.

105. The growing international debate and efforts by certain States to seek alternatives to punitive or repressive drug policies, including decriminalization and legal regulation, are welcome.

VII. Conclusions and recommendations

106. Investing in the right to health of adolescents offers huge potential to capitalize on positive investments in early years, while providing the opportunity to ameliorate the impact of negative early experiences and building resilience to mitigate future harm.

107. In their health-related and other policies aimed at investing in adolescents, States should be guided by the principle that adolescence is a period of development towards increasing capacity for independent decision-making. Adolescents need to be protected from violence, exploitation and other adversities, but the nature of those protections and their application must take into account the emerging competencies and evolving capacities acquired throughout adolescence.

108. States should invest in empowering adolescents by respecting their rights and autonomy, recognizing their capacities and investing in their health and resilience. All initiatives to address the physical, mental and sexual health of adolescents should be implemented in compliance with international human rights obligations, taking into account the views of adolescents and adopting evidence-based approaches.

109. Policies and services supporting families are a very important part of the efforts by States to ensure that adolescents thrive and grow up as healthy and responsible adults. These policies should respect and protect the human rights of all individual members of family and should exclude measures that undermine the rights of individual members of the family, including adolescents.

110. The Special Rapporteur would like to link his recommendations with the global call to double investment in adolescence as a major precondition of successfully attaining the 2030 Agenda for Sustainable Development and the Sustainable Development Goals.

111. In this connection, the Special Rapporteur recommends that Governments:

(a) Meet their core obligation to recognize adolescents as rights holders by respecting their evolving capacities and their right to participate in the design, delivery and evaluation of all policies and services affecting their health and well-being;

(b) Remove all legal barriers to health facilities, goods and services, such as consent laws that unduly infringe upon the rights of adolescents to be heard and to be taken seriously and, ultimately, upon their right to make autonomous decisions;

(c) Ensure the quality and timely collection of appropriately disaggregated data to inform public policy, and make the reality and needs of adolescents visible;

(d) Adopt a human rights framework for adolescent health, ensuring that health plans and strategies prioritize a holistic approach addressing underlying and

[89] Http://apps.who.int/iris/bitstream/10665/179865/1/WHO_HIV_2015.10_eng.pdf?ua=1.

social determinants and balancing curative service provision with investment in the resilience and autonomy of adolescents;

(e) Guarantee that health systems are responsive to the whole spectrum of health and psychosocial needs of adolescents, and ensure an integrated, multisectoral approach across social, child protective and education sectors;

(f) Ensure that health services are delivered in such a way as to respect adolescents' rights to privacy and confidentiality, address their different cultural needs and expectations and comply with ethical standards;

(g) Ensure that adolescents' health-care and other service providers, including social workers and educators, do not obstruct access to health facilities, goods and services by addressing discriminatory and stigmatizing attitudes and behaviours through information and awareness-raising campaigns;

(h) Ensure that a core package of health services, including both mental health and sexual and reproductive health services, are accessible to adolescents free of charge, and remove practical barriers presented by user fees with a view to developing a basic basket of services for adolescents as a part of their commitments to universal health coverage;

(i) Protect from interference and harm by non-State actors and third parties, including private service providers, by ensuring that they do not compromise the availability, accessibility, acceptability and quality of health-care and other relevant services, facilities and goods for adolescents;

(j) Protect adolescents from violence and neglect, including in family settings, by, inter alia, upholding their right to confidential services and counselling without parental consent;

(k) Take the measures necessary to support families, including through training and services, to increase the abilities of parents to raise children and adolescents in a competent and confident manner and reinforce skills to manage situations in a non-violent way;

(l) Support national human rights institutions to conduct national assessments or public inquiries into adolescents' right to health.

112. In connection to mental health, the Special Rapporteur recommends that Governments:

(a) In line with target 3.4 of the Sustainable Development Goals, formulate and implement a national adolescent mental health policy enabling the development of a spectrum of preventive and curatives services, in consultation with adolescents, that is sensitive to their rights and needs;

(b) Develop a system of adolescent mental health services that is mainstreamed into the community-based infrastructure of health, education and social welfare sectors;

(c) Design and implement adolescent-friendly psychosocial interventions at the community level in a manner that is ethical and consistent with adolescents' rights and on the basis of available evidence, in order to make such services accessible and acceptable and to avoid institutionalization and the excessive use of psychotropic medications;

(d) Ensure independent monitoring of mental health facilities providing services for adolescents with mental health conditions, including psychosocial and

intellectual disabilities, so that standards set by the Committee on the Rights of Persons with Disabilities are progressively implemented.

113. In connection to sexual and reproductive health rights, the Special Rapporteur recommends that Governments:

(a) In line with target 5.6 of the Sustainable Development Goals, adopt or integrate a comprehensive sexual and reproductive health policy for all adolescents into national strategies and programmes in order to ensure universal access to sexual and reproductive health-care services;

(b) Decriminalize abortion and guarantee all adolescents access to confidential, adolescent-responsive and non-discriminatory sexual and reproductive health information, services and goods, including on family planning, counselling, pre-conception care, maternal care, sexually transmitted infections, diagnosis and treatment, as well as modern forms of contraception, including emergency contraception, and safe abortion and post-abortion services;

(c) Ensure that sexual and reproductive health services are welcoming, adolescent-friendly, non-judgemental and guarantee privacy and confidentiality;

(d) Guarantee the provision of age-appropriate, comprehensive and inclusive sexuality education, based on scientific evidence and human rights, as part of the school curriculum;

(e) Repeal laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation or gender identity, and put an end to practices and treatments aimed at changing sexual orientation and gender identity.

114. In connection to substance use and drug control, the Special Rapporteur recommends that Governments:

(a) Close without delay all drug detention centres for adolescents, ensure the provision of prevention, harm reduction and dependence treatment services, without discrimination, and allocate a budget sufficient for the progressive realization of the right to health;

(b) Seek alternatives to punitive or repressive drug control policies, including decriminalization and legal regulation and control, and nurture the international debate on these issues, within which the right to health must remain central;

(c) Use the right to health framework to pursue strategies to prevent drug use among adolescents through evidence-based interventions as well as accurate and objective educational programmes and information campaigns.